CLIENT INTAKE PACKET

Regan Hager, LMHC
Pensacola Counselor

Section 1 | About You

Let's begin with some basic information. This section provides practical information I'll need before we meet.

Legal Name: _____Preferred Name: _____

Date of Birth: _____ Age: _____

Address: _____

City:_____State:_____ Zip:_____

Cell Phone: _____ ☐ May leave voicemail Email: _____

Occupation: _____Employer: _____

Highest Education Completed: _____Relationship Status: _____

Spouse's name:☐ N/A _____

Current Address or☐ Same as client:_____

Cell Phone: _____ Email: _____

Emergency Contact

Name: _____Relationship: _____

Phone: _____

Referral Information

How did you hear about my practice?

☐ Friend/Family ☐ Previous Client ☐ Therapist ☐ Psychology Today ☐ Google ☐ Other _____

If someone referred you, whom may I thank?

_____

Family Information

Do you have any children? ☐ Yes ☐ No

Child's Name	Date of Birth / Age

Do you have any siblings? ☐ Yes ☐ No

Sibling Name	Age	Relationship
		☐ Full ☐ Maternal Half ☐ Paternal Half ☐ Step
		☐ Full ☐ Maternal Half ☐ Paternal Half ☐ Step
		☐ Full ☐ Maternal Half ☐ Paternal Half ☐ Step
		☐ Full ☐ Maternal Half ☐ Paternal Half ☐ Step
		☐ Full ☐ Maternal Half ☐ Paternal Half ☐ Step

Medical Providers

Primary Care Provider: _____Date of Last Appointment: _____

Provider	Specialty	Last Appointment

Personal Health History

Do you currently have any medical conditions or chronic health concerns? ☐ Yes ☐ No

_____

_____

Current Medications & Supplements

Medication / Supplement	Dosage	Reason

Family Medical History

Condition	You	Mother	Father	Unknown
High Blood Pressure	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Asthma / Lung Disease	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐
Learning Disabilities	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐
Alcohol Abuse	☐	☐	☐	☐
Domestic Violence History	☐	☐	☐	☐

Is there any other medical or family history you believe would be helpful for me to know?

_____

_____

Section 2 | Your Story

Every person has a story. Before we talk about symptoms or diagnoses, I'd like to begin by learning about you. These questions help me understand what has brought you to counseling and what you hope will be different as a result of our work together.

What led you to seek counseling at this time?

What concerns you the most right now?

What do you hope counseling will help you accomplish?

If our work together is successful, what would be different in your life six months from now?

What strengths have helped you through difficult seasons of life?

What brings you joy?

Who currently lives in your home?

Who do you consider your primary support system?

When life feels overwhelming, what helps you feel even a little better?

Is there anything you hope I understand about you before we meet?

Section 3 | Your Life Journey

We'll spend much of our first appointment talking about the important chapters of your life. You don't need to list everything—only the experiences that feel significant to you. Please don't worry about remembering every detail or listing every difficult experience. There will never be pressure to discuss anything before you're ready.

Approximate Age / Season	Significant Life Event
Early Childhood	
Elementary Years	
Middle School	
High School	
College / Military	
Early Adulthood	
Relationships	
Career	
Birth of Children	
Losses / Grief	
Medical Events	
Traumatic Experiences (if comfortable sharing)	
Other Important Life Events	

Section 4 | Informed Consent for Counseling

Please read carefully. Ask any questions before signing.

Nature of Counseling

I voluntarily consent to evaluation and outpatient mental health counseling with Regan Hager, LMHC. Counseling is a collaborative process that may include assessment, treatment planning, education, discussion of thoughts and emotions, skill building, and trauma-focused approaches such as EMDR or somatic interventions when clinically appropriate and mutually agreed upon. I may ask questions, decline a particular intervention, or withdraw consent at any time. No specific outcome can be guaranteed.

Potential Benefits and Risks

Counseling may improve insight, coping, relationships, functioning, and symptom relief. It may also involve temporary discomfort, strong emotions, difficult memories, changes in relationships, or periods when symptoms feel more noticeable. Alternatives may include no treatment, another clinician, support groups, medication evaluation, higher levels of care, or other community resources. Referrals may be recommended when needs fall outside the clinician's scope or when a different level of care is indicated.

Appointments, Participation, and Ending Services

Sessions generally begin and end at the scheduled time. Arriving more than 15 minutes late may result in a shortened or rescheduled session. Regular attendance and active participation support treatment. Either the client or clinician may end services. When possible, termination will be discussed and referrals offered. Services may be paused or ended for nonpayment, repeated missed appointments, safety concerns, relocation outside a jurisdiction where treatment may legally occur, or when another provider or level of care is more appropriate.

Records and Professional Consultation

A clinical record will be maintained as required by law and professional standards. The clinician may consult with other qualified professionals for treatment or risk-management purposes while limiting identifying information whenever reasonably possible. Requests for records, letters, legal testimony, disability forms, or court involvement are separate professional services and may require written authorization, additional fees, and adequate notice. Counseling is not a forensic evaluation and does not guarantee that the clinician can provide opinions for legal proceedings.

Client Responsibilities and Emergency Care

I agree to provide accurate information, update changes in contact, health, medication, safety, insurance, and payment information, and participate in developing treatment goals. This practice does not provide 24-hour crisis coverage. For an immediate safety concern, call 911, go to the nearest emergency department, or contact an available crisis service. Email, voicemail, and text are not continuously monitored and should not be used for emergencies.

Acknowledgment

By signing, I confirm that I have read and understand this page, have had the opportunity to ask questions, and voluntarily consent to counseling services.

_____	_____	_____
Client/Responsible Party Signature	Date	Printed Name

Section 5 | Confidentiality, Privacy, Communication & Telehealth

Confidentiality and Its Limits

Counseling communications and records are generally confidential and protected by law. Information may be disclosed with my written authorization or without authorization when permitted or required by law. Examples include:

- reasonable suspicion of child abuse, abandonment, neglect, sexual abuse, or other reportable harm involving a child;
- reasonable suspicion of abuse, neglect, or exploitation of a vulnerable adult;
- a specific threat of serious bodily injury or death to an identifiable or readily available person when the clinician determines there is apparent intent and ability to carry it out;
- circumstances requiring emergency intervention or evaluation because of a serious and imminent safety concern;
- a valid court order, legal proceeding in which mental condition is placed at issue, professional defense, licensing investigation, or another disclosure permitted or required by law;
- treatment, payment, or health-care operations as allowed by applicable privacy law.

When more than one person participates in a session, each person is expected to respect privacy; however, the clinician cannot guarantee that another participant will maintain confidentiality. The clinician does not provide couples counseling through this practice.

HIPAA Notice of Privacy Practices

I acknowledge that I have received or been offered Regan Hager, LMHC's Notice of Privacy Practices, which explains permitted uses and disclosures of protected health information, my privacy rights, the practice's legal duties, and how to raise a privacy concern. Signing this acknowledgment confirms receipt or offer of the Notice; it is not an authorization for uses or disclosures beyond those allowed by law. The current Notice is available in the office and on the practice website.

Electronic Communication

Email, text, voicemail, and online scheduling may be used for administrative matters such as scheduling, forms, and billing. These methods may carry privacy risks and are not appropriate for emergencies or detailed clinical communication. Messages may become part of the clinical record. Response times are not guaranteed outside business hours. Please mark any method that should NOT be used:

☐ Phone call ☐ Voicemail ☐ Text message ☐ Email ☐ Physical mail

Telehealth Consent

Telehealth may be offered after an in-person intake when clinically appropriate. I understand that telehealth uses electronic communication and may involve risks such as technology failure, interruptions, unauthorized access, or reduced access to emergency support. At each telehealth session I will be physically located in a jurisdiction where the clinician may legally provide services, use a reasonably private setting, and provide my current location and an emergency contact if requested. The clinician may end or convert a telehealth session when privacy, safety, technology, or clinical needs make remote care inappropriate. Standard fees, cancellation policies, confidentiality rules, and documentation practices apply to telehealth.

Acknowledgment

By signing, I acknowledge the limits of confidentiality, privacy practices, communication risks, emergency procedures, and telehealth terms described above.

_____	_____	_____
Client/Responsible Party Signature	Date	Printed Name

Section 6 | Financial, Cancellation & Payment Authorization

Fees and Payment Responsibility

The standard individual counseling fee is $150 per session unless a different fee has been agreed upon in writing. Payment is due at the time services are provided. I am financially responsible for all charges, including charges not paid by an insurance plan or other third party. This practice is self-pay unless otherwise specifically arranged. Upon request, a receipt or superbill may be provided; reimbursement is not guaranteed and may require disclosure of a diagnosis or other information to the payer.

Cancellation and Missed Appointment Policy

Because appointment time is reserved exclusively for me, I agree to provide at least 48 hours' notice to cancel or reschedule. Appointments canceled with less than 48 hours' notice and missed appointments will be charged the full session fee of $150, except when the clinician determines that an exceptional circumstance warrants otherwise. Insurance generally does not reimburse late-cancellation or no-show fees. Repeated missed or late-canceled appointments may result in a change in scheduling arrangements or termination of services.

Balances, Returned Payments, and Collection

Outstanding balances are due promptly. The practice may charge a returned-payment fee to the extent permitted by law and may suspend scheduling while a balance remains unpaid. If an account is referred for collection or legal action, only the minimum information reasonably necessary may be disclosed as permitted by law. I am responsible for reasonable collection costs when allowed by law.

Credit/Debit Card on File Authorization

A valid payment method must remain on file with the practice's secure payment processor. I authorize Regan Hager, LMHC to charge the payment method on file for: (1) session fees when I request or approve use of the card; (2) late-cancellation and missed-appointment fees; and (3) other undisputed balances owed under this agreement. I understand that a receipt will be available and that I may revoke this authorization in writing for future charges, but revocation does not eliminate amounts already owed and may affect eligibility for continued services if no valid payment method remains on file. Card details should be entered directly into the secure payment system rather than written on this form.

Credit Card Number:_____ Name as it appears on card: _____

Expiration Date (mm/yy): _____ 3 digit (4 digit for AMEX) CVV/CVC number: _____

Billing Zip Code: _____

I approve the card below be utilized as a form of payment for session fees: ☐ Yes ☐ No

Acknowledgment

By signing, I confirm that I understand and agree to the fees, 48-hour cancellation policy, payment responsibility, balance terms, and payment authorization on this page.

_____	_____	_____
Client/Responsible Party Signature	Date	Printed Name